

FOR VDDHH ISP OFFICE USE ONLY

ASSIGNED:	Job #:
Confirmed (date/by):	Entered by:
PO Requested (VDDHH Paid only)	

VIRGINIA DEPARTMENT FOR THE DEAF AND HARD OF HEARING
GENERAL SIGN LANGUAGE Interpreter/CART Request Form EMAIL TO isprequests@vddhh.virginia.gov
(Items marked with (▶) REQUIRED for form to be complete)

▶ <i>Please check the appropriate box below for Communication Services you need:</i>				
<input type="checkbox"/> INTERPRETER(s)		<input type="checkbox"/> CART PROVIDER(s) ON-SITE		<input type="checkbox"/> BOTH
▶ Today's Date:		▶ NAME OF AGENCY REQUESTING SERVICE:		
▶ NAME of PERSON SUBMITTING THIS FORM ("Requestor") :			▶ Requestor Phone Number:	
▶ AGENCY ADDRESS:			▶ Requestor Email Address :	
▶ Date(s) of Assignment (if multiple dates, provide start and end times for each date in the description box below):				
▶ Beginning Time of Assignment:		▶ End Time of Assignment (if none provided, two hour minimum will be assumed):		Comments on time of assignment:
▶ Location/Address of Assignment (IF NOT AT AGENCY ADDRESS): (include bldg, floor, room #, etc.)				
▶ On-Site Contact Person:		▶ On-Site Phone Number: Cell? Office?		On-Site Contact Email Address:
▶ Type of Assignment (select all that apply):		▶ Number of interpreters needed/requested :		
<input type="checkbox"/> Medical appt <input type="checkbox"/> Mental Health appt <input type="checkbox"/> Small Group Mtg <input type="checkbox"/> Large Group Mtg <input type="checkbox"/> Interview <input type="checkbox"/> Other:		<input type="checkbox"/> Admin. Hearing appointment <input type="checkbox"/> Intake <input type="checkbox"/> Training <input type="checkbox"/> Conference		
▶ Provide a Brief Description of Situation/Nature of Assignment . Attach any agenda or available prep materials to your request:				
▶ Name/Role of All Key Parties				
NAME	ROLE	DEAF?	AGE	GENDER
		<input type="checkbox"/>		
OPTIONAL: Requested Interpreter/CART Providers:				
For CART Provider Request: Equipment: Please check # of users below: 1-2 users – laptop: ____ 2-3 users – monitor: ____ 3+ users – screen: ____		For Sign Language Interpreter Request: Specific Communications Needs (if known) ASL PSE SEE Close-vision Tactile Other (explain):		

CONTINUE TO NEXT PAGE TO PROVIDE BILLING INFORMATION. REQUEST WILL NOT BE PROCESSED WITHOUT COMPLETE BILLING ADDRESS AND AUTHORIZATION.

Billing Information – Your request will NOT be processed without billing information. By providing this information, you acknowledge that you are authorized to ensure payment by the named entity at the contract rate and under contract terms for the services of a qualified sign language interpreter/CART provider. If no contract interpreter is available, you will be notified of the rate for any non-contracted interpreter assigned.

▶Bill Person:	▶Phone Number Ext.
▶Agency Name:	Email Address:
▶Street Address:	
▶City, State. Zip	
<input type="checkbox"/> Check if emailed invoices are accepted.	<input type="checkbox"/> Check if your agency participates in the VDDHH Contract for Sign Language Interpreters.